APPENDIX

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APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 94-55947
D.C. No. CV-94-00524-SVW

IT CORPORATION; IT CORPORATION BENEFIT PLAN;
HARRY JOSEPH LUKOWSKI,
Plaintiffs-Appellants,

v.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant-Appellee.

Appeal from the United States District Court
for the Central District of California
Stephen V. Wilson, District Judge, Presiding

Argued and Submitted December 12, 1995
Pasadena, California

Filed March 3, 1997

Before: Procter Hug, Jr., Chief Judge, Robert R. Beezer, and Andrew J. Kleinfeld, Circuit Judges.

Opinion by Judge Kleinfeld

OPINION

KLEINFELD, Circuit Judge:

The issue in this ERISA case is whether a health benefits plan administrator can be sued as a fiduciary. We conclude that in this case dismissal of the claims against the administrator was error, because of questions regarding the administrator's discretionary authority, and also its control of plan money.

Facts

The district court dismissed this action on the ground that the defendant was, under its contractual undertaking, not an ERISA fiduciary. Though the case came before the district court on a 12(b)(6) motion to dismiss, the court considered the contracts between IT Corporation and General American (attached to the motion), as well as the complaint, so we review the dismissal de novo as on summary judgment. United States v. Grayson, 879 F.2d 620, 625 n.8 (9th Cir. 1989). The appeal does not argue procedural irregularity, so we do not consider it.

IT Corporation hired General American Life Insurance Company to administer IT's ERISA plan. Under the Administrative Services Agreement which General American had IT Corporation sign, IT was to establish a bank account and keep enough money in it to cover checks. General American had checkwriting authority. General American was to process claims, and pay or deny them. The contract says that Geenral American "shall pay all claims which it has determined to be payable under the agreement, except . . . all contested or doubtful claims or benefits amounts shall be referred to the client for its determination of liability and instruction."

The complaint alleges that General American paid over $600,000 for medical expenses relating to an IT Corporation employee's dependent child. According to the complaint, the child was ineligible for benefits, and General American paid $600,000 from the ERISA plan bank ac-

count in violation of the terms of the plan. There are three plaintiffs: the plan, IT Corporation, and a participant-employee.

The plan included a number of clauses designed to limit General American's liability in the event of error or misjudgment. IT Corporation and General American agreed that General American would be "acting only as agent of" IT, and would "not be liable for any mistake of judgment or other action taken in good faith, or for any loss unless resulting from its gross negligence." One clause in the agreement General American obtained from IT said that "under no circumstances shall the service contractor [General American] be considered the named fiduciary under the Plan." The agreement further provided: "Each individual administrative act, decision and interpretation by [General American] (including any errors, clerical or otherwise) shall be binding upon the [IT] with respect to past performance or completed action."

Basically, General American was supposed to refer doubtful claims to IT, but IT would ordinarily not even know about a claim unless and until General American exercised its judgment to decide that the claim was doubtful. In routine medical claims, General American was to conduct "verification of employee eligibility as to coverage and benefits" and provide "claim control practices," and then pay the claims as it deemed appropriate and provide monthly reports of claim payments. General American was to "consult with [IT Corporation] or legal counsel designated by [IT] in claim matters that are beyond the ordinary." The contract provided that General American "shall investigate the validity of each claim . . . and shall compute the benefits payable, if any, on each such claim." Then General American "shall pay all claims which it has determined to be payable under the agreement," except that "[a]ll contested or doubtful claims or benefit amounts shall be referred to the client

for its determination of liability and instruction to the service contractor." IT Corporation retained authority to "resolve any disputes which may arise with regard to the rights of persons covered under the Plan, including but not limited to eligibility for participation and claims for benefits."

Analysis

1. Contractual Exoneration.

Though General American did much to exonerate itself from responsibility by means of the contract it had IT Corporation sign, the contractual exoneration cannot do it much good in this case. There are several reasons why not. First, a contract exonerating an ERISA fiduciary from fiduciary responsibilities is void as a matter of law. Second, a fiduciary's contract with an employer cannot get it off the hook with the employees who participate in the ERISA plan. They did not sign a contract exonerating the fiduciary. Third, a contract providing that a party is not a named fiduciary does not mean that it is not an unnamed fiduciary. Fourth, discussed in section 2, below, the contract does not limit General American's tasks to the purely ministerial.

If an ERISA fiduciary writes words in an instrument exonerating itself of fiduciary responsibility, the words, even if agreed upon, are generally without effect. With exceptions not relevant to this case, ERISA provides that "any provision in an agreement or instrument which purports to relieve a fiduciary from responsibility or liability for any responsibility, obligation, or duty under this part shall be void as against public policy." 29 U.S.C. § 1110(a). If General American is a fiduciary, as defined in section 1002(21)(A), "any interpretation of the Plan which prevents [General American] acting in a fiduciary capacity from being found liable as [a] fiduciar[y] is void." *Kayes v. Pacific Lumber Co.*, 51 F.3d 1449, 1460 (9th Cir.), cert. denied, 116 S.Ct. 301 (1995). "ERISA defines fiduciary not in terms of formal trusteeship, but in func-

tional terms of control and authority over the plan, thus expanding the universe of persons subject to fiduciary duties—and to damages—under § 409(a)." *Id.* at 1459 (quoting *Mertens v. Hewitt Assocs.*, 113 S. Ct. 2063, 2071 (1993)) (emphasis in original).

Even if General American could by contract exonerate itself from fiduciary responsibilities to IT Corporation, there is no reason to suppose that the contract would exonerate General American from its duties to participants and beneficiaries of the ERISA plan. 29 U.S.C. §§ 1104, 1110(a); cf. Restatement (Second) of Trusts § 216, comment i (1959). The participant-employee plaintiff did not sign the contract with the exonerating provisions, and he is entitled to have the plan administered in the interest of participants and beneficiaries. 29 U.S.C. § 1104. The ERISA Plan itself also sued for breach of what it claimed was General American's fiduciary responsibility to the Plan.

The contract says that "under no circumstances shall the service contractor [General American] be considered the named fiduciary under the Plan." The word "named" in this provision leaves open the possibility that General American may be an unnamed fiduciary. There is a difference under ERISA, between a "named fiduciary," under 29 U.S.C. § 1102(a), and a "fiduciary" under 29 U.S.C. § 1002(21)(A). Named fiduciaries are a subset of fiduciaries.

2. Fiduciary Status.

The most substantial argument for exonerating General American is that it was not a fiduciary, because its duties were purely ministerial. The contract says:

> It is understood that the Service Contract [General American] performs purely ministerial functions for the Client [IT Corporation] within a framework of

> policies, interpretations, rules, practices and procedures made by the Client.

Though based on the contract, General American's "purely ministerial" argument is not subject to the weaknesses of contractual exoneration. It is one thing to say "we promise to act as a fiduciary, but we shall not be subject to the liabilities of fiduciaries to beneficiaries." That generally cannot be done. It is different to say "we will do certain things for you, but only cut and dried things under your direction, not any of those acts which would make us a fiduciary." That can work. If a fiduciary tells a bookkeeping service to send a check for $950 to Mercy Hospital, the bookkeeping service does not thereby become a fiduciary.

The words General American used in its contract, "purely ministerial functions," were obviously written to fit the established legal understanding of what acts could be done without turning General American into a fiduciary. The Department of Labor has issued "questions and answers" regarding the distinction between persons performing "ministerial duties" and fiduciaries. These "questions and answers" distinguish persons performing "purely ministerial functions" from fiduciaries:

> Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above, for an employee benefit plan within a framework of policies, interpretations rules, practices, and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or disposition of the assets of the plan, and does not render investment advice with respect

> to any money or other property of the plan and has no authority or responsibility to do so.

29 C.F.R. § 2509.75-8 at D-2 (emphasis added). But putting the magic words in the contract, "purely ministerial duties," does not avoid fiduciary responsibility, if the characterization, "purely ministerial duties," is not correct. The issue is not just how the duties are characterized, but what they are.

The plaintiffs' theory is that General American breached its fiduciary duty to Plan participants by paying over $600,000 on a non-eligible claim, thereby depleting the amount available for proper claims. If General American was a fiduciary, and if it breached its fiduciary duty, then it would have to make good any loss resulting from its breach. 29 U.S.C. § 1109(a). General American argues it was not a "fiduciary" as defined by ERISA. We conclude, for two reasons, that General American may be a fiduciary, and was not entitled to judgment as a matter of law on this record that it was not. First, its discretionary authority and control may exceed what could properly be characterized as "purely ministerial" activities. Second, authority and control over plan assets may make it a fiduciary.

a. Discretionary Authority.

ERISA makes a person who exercises "discretionary authority or discretionary responsibility" in plan administration a fiduciary:

> . . . [A] person is a fiduciary with respect to a plan to the extent [i] he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or [iii] he has any discretionary authority or dis-

> cretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added).

The Department of Labor's "questions and answers" do not resolve whether General American's duties respecting IT Corporation's ERISA plan were "discretionary" or "purely ministerial." "[P]ersons who have no power to make any decisions as to plan policy, interpretation, practices or procedures" are not fiduciaries. 29 C.F.R. § 2509.75-8 at D-2. A plan employee "whose sole function is to calculate the amount of benefits to which each plan participant is entitled in accordance with a mathematical formula," does not thereby become a fiduciary. But a plan employee "who has the final authority to authorize or disallow benefit payments in cases where a dispute exists" is a fiduciary. *Id.* at D-3.

One could say that General American has no final authority to authorize or disallow benefits in disputed cases, because the contract requires it to refer disputed cases back to IT Corporation. But it is hard to say that General American has no power to make decisions about plan interpretation, because General American has to interpret the plan to determine whether a benefits claim ought to be referred back. No claim is likely to be known to or disputed by IT Corporation unless and until General American decides that it is questionable or doubtful enough to be worth referring back to IT Corporation for instructions.

ERISA health benefits in this case cannot be calculated from a mathematical formula, as retirement benefits might be if the plan made them depend solely on date of birth, date of entry into service, gross pay for last three years of service, and date of retirement. So far as the record shows, this ERISA plan did not have a schedule of illnesses and medical treatments with a dollar limit, to delineate routine claims from those which should be referred back to IT

Corporation. So far as we can tell from the record, General American's decisions about claims would have to have involved plan interpretation and judgment, not just typing a treatment code number and treatment provider identification onto a computer screen for generation of a payment check. The contract says that General American "performs purely ministerial functions for the client within a framework of policies, interpretations, rules, practices and procedures made by the client." That framework is strikingly elaborate for its application to be purely ministerial. Federal appellate judges merely apply law to facts within a framework of statutes, rules, and precedent which binds them, but because of the multifariousness of facts and complexities of application of this elaborate framework, the task often involves difficult and close questions of judgment. Calling interpretation and judgment "purely ministerial" does not make it so.

There is tension between our decisions in *Yeseta v. Baima,* 837 F.2d 380, 385-86 (9th Cir. 1988) and *Kyle v. Pacific Administration Services, Inc.,* 990 F.2d 513 (9th Cir. 1993), regarding whether a firm providing services is an ERISA fiduciary. In *Yeseta,* the person managing the profit sharing plan was instructed by one of the principles in the company to pay him an amount in excess of what he was entitled to. We held that whether the person "was authorized to make the . . . withdrawals or not, he did exercise control over and disposed of Plan assets. His acts in this respect were not ministerial. On this basis, Yeseta is a fiduciary under § 1002(21)." *Id.* at 386. On the other hand, in *Kyle,* we held that a health plan administrator which was to "refer all discretionary questions regarding the payment of claims" to the employer was not a fiduciary, because its functions were "merely ministerial." See 990 F.2d at 516.

Kyle is distinguishable because the question there was merely whether paying non-covered claims, paying claims twice, and paying them late, was enough power to make

the administrator a fiduciary. The power to err, as when a clerical employee types an erroneous code onto a computer screen, is not the kind of discretionary authority which turns an administrator into a fiduciary. It may turn out, when the record is more fully developed, that General American had no discretion, and was just hring clerical employees to type codes and mail checks, but the record does not now show that its duties were purely ministerial. For all we know from the record as it stands, General American paid $600,000 on a non-covered medical claim, not through clerical error, but because it had considerable discretion and made a misjudgment about plan interpretation. That would be more like *Yeseta*.

b. Control Over Assets.

There is a second reason, which does not depend on whether General American had discretion, why it may be a fiduciary. The record as it stands shows that General American controlled the money in the plan's bank account. The statute treats control over the cash differently from control over administration. The statutory qualification, that control must be "discretionary" for it to establish fiduciary status, applies to the first and third phrases, management and administration but not to the second, assets. "Any" control over disposition of plan money makes the person who has the control a fiduciary:

> . . . [A] person is a fiduciary with respect to a plan to the extent [i] he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, . . . or [iii] he has any discretionary authority or discretionary responsibility in the administration of such plan.

On the record as it stands, IT Corporation was to keep the plan bank account filled with money, and General

American would write checks on the bank account. IT was to set up a bank account, "as the depository for funds to be used by [General American] to make payments." IT was required to notify the bank that General American was authorized "to issue and accept checks drawn on such account." IT had the "responsibility to maintain funds in this account sufficient to cover all checks validly issued by the service contractor's authorized employees." This provision means that a practical matter, a substantial amount of money would be under the control of General American, in the form of a bank account which it could deplete by writing checks.

The right to write checks on plan funds is "authority or control respecting management or disposition of its assets." We need not decide, because the case never got to the stage of cross motions for summary judgment, whether General American's authority to instruct the plan's bank to pay money to the order of drawees makes it a fiduciary as a matter of law. Its authority under the plan to do so cannot be reconciled with holding that it is a non-fiduciary as a matter of law. Only that issue is before us because of the early stage at which the case was dismissed. The words of the ERISA statute, and its purpose of assuring that people who have practical control over an ERISA plan's money have fiduciary responsibility to the plan's beneficiaries, require that a person with authority to direct payment of a plan's money be deemed a fiduciary.

Authority over a plan's money is not the same thing as being a depository of the money. If the plan's money is deposited in a bank, that does not ipso facto make the bank a fiduciary. *Arizona State Carpenters Pension Trust Fund v. Citibank* (*Arizona*), 96 F.3d 1310, 1317 (9th Cir. 1996). When money is deposited in a bank, generally the bank has no authority over who the money is paid to, and the bank manages its own money, not the depositor's,

because the depositer loans its money to the bank for its own use. People with checking accounts do not worry that their banks will pay out their money to persons of the bank's choice, because the bank has no authority or control entitling it to pay anyone but payees and endorsees on checks. Unlike Citibank in *Arizona Carpenters,* General American had authority to write checks, that is, to dispose of plan assets.

CONCLUSION

The judgment dismissing the claims is REVERSED. The case is REMANDED for further proceedings.

[Filed May 24, 1994]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CV 94-0524 SVW (Sx)

IT CORPORATION, *et al.*,
Plaintiffs,

v.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant.

ORDER GRANTING MOTION TO DISMISS

In this matter, Plaintiffs allege that Defendant General American Life Insurance Company ("General American") breached its statutory ERISA fiduciary duty under 29 U.S.C. § 1104. General American moves to dismiss on the ground that the underlying Administrative Services Agreement between General American and Plaintiff IT Corporation establishes that General American is not an ERISA fiduciary under 29 U.S.C. § 1002(21). The Court agrees and the motion will be granted.

This issue is governed by *Kyle Railways v. Pacific Administration Services, Inc.*, 990 F.2d 513 (9th Cir. 1993). In *Kyle*, the Ninth Circuit held that an entity is an ERISA fiduciary only if the entity exercises *discretionary* authority or control respecting the management or administration of an employee benefit plan. *Id.* at 516. In *Kyle*, as in the present case, the plan sponsor sought to sue the plan's administrator for "paying claims not covered under the plan." *Id.* at 515. Without quoting the contractual provi-

sions involved in the dispute, the Ninth Circuit held that the plan administrator was not given any discretionary authority under the administration agreement and that the administrator was therefore not a fiduciary under ERISA. *Id.* at 516.

In order to determine whether *Kyle* directly governed the present matter, the Court has obtained from the Ninth Circuit the briefing underlying the *Kyle* decision. As established in the appellant's opening brief in *Kyle*, the Kyle plaintiff unsuccessfully urged a finding of fiduciary duty for the plan administrator, Pacific, based on the following contractual provisions:

> (1) If requested Pacific would prepare an employee booklet describing eligibility, benefits, limitation and exclusions, and any changes thereto;
>
> (2) Pacific will determine the eligibility of employees to receive payment and shall determine in accordance with the Plan the qualification of claims submitted by such eligible employees making such reasonable investigation as shall be deemed necessary by Pacific;
>
> (3) Pacific will submit a monthly accounting to Kyle of the amounts spent on behalf of Plan participants;
>
> (4) Kyle shall deposit with Pacific the sums that Pacific determines are necessary in order to pay claims and other expenses connected with the administration of the claim.

In reaching the conclusion that these obligations did not create a fiduciary duty, the *Kyle* Court relied in large part on 29 C.F.R. § 2509.75-8(D-2). Subsection D-2 lists the following as ministerial functions not creating a fiduciary relationship:

> (1) *Application of rules determining eligibility for participation and benefits;*

(2) Calculations of services and compensations credits for benefits;

(3) Preparation of employee communications material;

(4) Maintenance of participants' service and employment records;

(5) Preparation of reports required by government agencies;

(6) *Calculation of benefits;*

(7) Orientation of new participants and advising participants of their rights and options under the plan;

(8) Collection of contributions and applications of contributions as provided in the plan;

(9) Preparation of reports concerning participation benefits;

(10) *Processing of claims;*

(11) Making recommendations to others for decisions with respect to plan administration. (emphasis added).

The present plaintiffs rely upon the following obligations of General American under their "Administrative Services Agreement" in support of the claim that a fiduciary duty existed:

(1) Evaluate evidence of good health for late enrollees;

(2) Claim control standards and practices;

(3) Verification of employee eligibility as to coverage and benefits—IT Corporation is required to supply information concerning changes in employee coverage; and

(4) Audit procedures and claim practices.

These responsibilities are precisely the type of plan administration responsibilities that are addressed by *Kyle* and by Subsection (D)(2).

The Court further notes that *Kyle* specifically addressed other contractual provisions that are also present in the contract underlying the present dispute. As in *Kyle*, the Administrative Services Agreement requires the administrator to refer all discretionary questions regarding the payment of claims to the employer. ("[General American] shall consult with [IT Corporation] in claim matters that are beyond the ordinary.") ("All contested or doubtful claims of benefit amounts shall be referred to [IT Corporation] for its determination of liability.") Also, as in *Kyle*, the Administration Services Agreement requires General American to follow the Plan *as established by* IT Corporation.

While Courts outside this circuit may disagree, *see Greenblatt v. Prescription Plan Services Corp.*, 783 F. Supp. 814 (S.D.N.Y. 1992), Ninth Circuit law establishes that plan administrators that determine eligibility for plan benefits, under the circumstances herein, are not ERISA fiduciaries. Therefore, the motion to dismiss must be granted.

THE COURT HEREBY ORDERS THAT THE MOTION TO DISMISS IS GRANTED.

IT IS SO ORDERED.

DATED: May 17, 1994

/s/ Stephen V. Wilson
STEPHEN V. WILSON
United States District
Judge

[Filed Jun. 23, 1997]

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 94-55947
D.C. No. CV-94-00524-SVW

IT CORPORATION, IT CORPORATION BENEFIT PLAN;
HARRY JOSEPH LUKOWSKI,
Plaintiffs-Appellants,

v.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant-Appellee.

ORDER

Before: HUG, Chief Judge, BEEZER, and KLEINFELD, Circuit Judges.

The panel has voted to deny the petition for rehearing. Chief Judge Hug and Judge Kleinfeld have voted to reject the suggestion for rehearing en banc. Judge Beezer so recommends.

The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35(b).

The petition for rehearing is DENIED and the suggestion for rehearing en banc is REJECTED.

[Filed Jan. 25, 1994]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. 94 0524 SVW

IT CORPORATION; IT CORPORATION BENEFIT PLAN; HARRY JOSEPH LUKOWSKI,
Plaintiffs,

vs.

GENERAL AMERICAN LIFE INSURANCE COMPANY,
Defendant.

COMPLAINT FOR BREACH OF FIDUCIARY DUTY BY ERISA FIDUCIARIES

Plaintiffs allege:

GENERAL ALLEGATIONS

1. Jurisdiction of this Court is invoked pursuant to 29 U.S.C. Section 1132(e) on the basis that this action is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. 1001, et. seq.

2. Plaintiff IT Corporation is the plan sponsor of the IT Corporation Benefit Plan. Plaintiff IT Corporation Benefit Plan ("IT Plan") is a self-funded plan which provides hospital and medical benefits to its members. Defendant General American Life Insurance Company ("General American") is the administrator for the IT Plan. Plaintiff Harry Joseph Lukowski is an employee of IT Corporation and a participant in the IT Plan.

FIRST CLAIM FOR RELIEF

(Claim for Breach of Fiduciary Duties by ERISA Fiduciary Against General American)

3. Plaintiffs hereby repeat and reallege Paragraphs 1 and 2 and incorporates the same as though fully set forth herein.

4. Effeceive December, 1987, plaintiff IT Corporation and General American entered into an agreement ("Administration Agreement") whereby General America would act as the Administrator of the IT Plan, a self-funded employee benefit plan.

5. The Administration Agreement required that IT Corporation deposit funds in a bank account for use by General American in paying claims made by participants and beneficiaries of the IT Plan, and that General American had the right to issue and accept checks drawn on that account. The acceptance of responsibility for these funds by General American for its use created a fiduciary duty owed by General American to the IT Plan and to its participants and beneficiaries.

6. The Administration Agreement required that General American verify the eligibility of each participant or beneficiary for benefits under the terms of the IT Plan prior to paying any claim for said benefits.

7. The terms of the IT Plan excluded from eligibility for IT Plan benefits any employee's dependent who was unable to carry on the duties and activities of a person of similar age.

8. IT Corporation employee Jim Martin submitted claims for benefits on behalf of his dependent child, Noah. Noah Martin was unable to carry on the duties and activities of a person of similar age, and was therefore ineligible for benefits under the terms of the IT Plan.

9. General American failed to verify the eligibility of Noah Martin, and paid in excess of $600,000 in claims

from the assets of the IT Plan in violation of the terms of the IT Plan, and of the Administrator Agreement between IT Corporation and General American. Said sums in excess of $600,000 were taken from the bank account wherein funds were deposited by IT Corporation for use by General American in paying claims under the IT Plan for eligible participants and beneficiaries.

10. General American refused to reimburse the assets of the IT Plan for the monies expended for payment of the claims of Noah Martin, who was not a participant or beneficiary of the IT Plan.

12. General American's acts in payment of IT Plan assets to benefit a person other than a participant or beneficiary of the subject plan are in violation of 29 U.S.C. Section 1104(A) and (B), and this action is properly brought before the Court pursuant to 29 U.S.C. Section 1009(a) and 29 U.S.C. Section 1132(a).

13. As a result of General American's acts in refusing to reimburse the IT Plan for the sums paid in violation of the terms of the IT Plan, the IT Plan's assets have been depleted by all such sums, to the detriment of the IT Plan's participants and beneficiaries. Payment of such sums in violation of the terms of the IT Plan was a breach of General American's express and implied fiduciary duties towards the IT Plan's participants and beneficiaries to hold said assets solely for their benefit, and distribute said assets solely on the behalf of the participants and beneficiaries of the IT Plan.

14. Plaintiffs are therefore entitled to receive from General American all sums taken from the IT Plan's assets for wrongful payment on behalf of Noah Martin, who was neither a participant or beneficiary of the IT Plan, and attorneys' fees, interest and costs incurred in connection with this lawsuit.

WHEREFORE, plaintiff prays for judgment as follows against defendants:

1. Recovery of all sums paid for treatment of Noah Martin;

2. Attorneys' fees;

3. Costs of suit incurred herein; and

4. For such other and further relief as this Court may deem just and proper.

DATED: January 20, 1994

GIANELLI & MORRIS

By /s/ Robert S. Gianelli
ROBERT S. GIANELLI
Attorney for Plaintiffs

EMPLOYEE MEDICAL BENEFITS PLAN DOCUMENT

Article I. Establishment of the Plan

1.1 The Plan. IT CORPORATION (the Employer) hereby establishes a plan of medical and dental benefits for its Employees. This plan will be known as the IT CORPORATION Medical and Dental Benefit Plan (the Plan) and is effective as of January 1, 1991. This Plan is designed to provide Employees and their Eligible Dependents with significant financial protection against the economic strain that might result from illness or injury.

1.2 Legal Status. This Plan will constitute an employee welfare benefit plan under the Employee Retirement Income Security Act of 1974 and has been reduced to writing in order to comply with ERISA Section 402.

1.3 Plan Document. The plan document consists of two parts: Part One includes Articles I through V and any amendments thereto; Part Two includes the attached Summary Plan description of Medical and Dental Care Benefits bearing an Effective Date of January 1, 1991, together with any amendments thereto.

Article II. Definitions

2.1 Employee means any individual employed by the Employer and to the extent necessary, a retired or terminated Employee entitled to receive benefit payments under this Plan.

2.2 Participant means an Employee who has elected to participate in the Plan.

2.3 Eligible Dependent means an individual defined under the Plan as an eligible dependent.

2.4 Plan Claim Administrator means the entity designated by the Employer to pay claims for benefits.

2.5 Plan Administrator means the Employer.

Article III. Funding

3.1 Source of Funds. The funding medium for the Plan is funds contributed by the Employer from its general assets and by Participants. The amount of Participant contributions shall be as determined by the Employer from time to time.

Article IV. Payment of Claims

4.1 Submision of Claims. Claims for benefits under the Plan shall be submitted to the Plan Claim Administrator and in accordance with the procedures described in the Summary Plan Description in effect at the time claim is submitted.

4.2 Appeal of Denied Claim. An Employee or Eligible Dependent whose claim is denied in whole or in part may appeal such denial in accordance with the claim review procedures described in the Summary Plan Description.

Article V. General Provisions

5.1 Plan Administrator. The Plan shall be administered by the Employer, which shall have the authority to construe and interpret the terms of the Plan, and resolve any disputes which may arise with regard to the rights of persons covered under the Plan, including but not limited to eligibility for participation and claims for benefits. The Administrator shall be responsible for maintaining all records relating to the administration of the Plan and for complying with all reporting, filing and disclosure requirements established by the Internal Revenue Service and Department of Labor applicable to employee welfare benefit plans.

5.2 Rules and Decisions. The Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator

shall be uniformly and consistently applied to all Participants in similar circumstances. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished by a Participant, the Plan Claim Administrator, or legal counsel.

5.3 Nonalienation of Benefits. Benefits payable under this Plan shall not be assigned, transferred, or pledged as collateral prior to their actual receipt by the person entitled thereto under the terms of the Plan.

5.4 Termination and Amendments. The Employer intends that this Plan will continue in effect indefinitely, but reserves the right to amend or terminate the Plan at any time.

IN WITNESS WHEREOF, the Employer has caused this Plan to be executed by its duly authorized officers on this ____ day of _____, 19__.

_____

Title: _____

_____

Title: _____

ADMINISTRATIVE SERVICES AGREEMENT
BY AND BETWEEN
IT CORPORATION
(Herein called the Client)

AND

GENERAL AMERICAN LIFE
INSURANCE COMPANY
(Herein called the Service Contractor)

Whereas, the Client desires to provide benefits for certain classes of individuals in acordance with a written plan (hereinafter called "the Plan") as described in Appendix D;

Whereas, under said Plan the Client will bear all liabilities but desires that the Service Contractor provide certain services in connection with the administration and operation of the Plan;

Now, therfeore, in consideration of the payments to the Service Contractor as provided in the Payment Schedule, Appendix B, and subject to the terms and conditions contained herein, it is hereby agreed as follows:

Section 1. Services

The Service Contractor will provide the services listed in Appendix A subject to modification as provided herein, for the administration and operation of the Plan; such services to be coordinated by a representative of the Service Contractor to assure effective and efficient operation of the Plan.

Section 2. Banking Arrangements

The Client shall establish a separate Benefit Plan Account in a bank as the depository for funds to be used by the Service Contractor to make payments pursuant to this

Agremeent and the Plan. The Client shall notify said bank that they have authorized the Service Contractor, by execution of this Agreement, to issue and accept checks drawn on such account on behalf of the Client for the purpose of payment of benefits under the Plan. It shall be the Client's responsibility to maintain funds in this Account sufficient to cover all checks validly issued by the Service Contractor's authorized employees.

Section 3. Client Reports, Records and Information

The Client hereby agrees to furnish the Service Contractor with certain necessary reports, records, and information in order to carry out its duties hereunder.

It is mutually agreed that the Service Contractor shall not be responsible for delay in the performance of its duties under this Agreement or for non-performance hereunder. If such delay or non-performance is caused or contributed to in whole or in part by the failure of the Client to promptly furnish any required information.

Section 4. Payments to the Service Contractor

For each month in which the Service Contractor performs duties pursuant to this Agreement, the Client shall make payment to the Service Contractor of amounts due within 10 days of the date of notification to the Client by the Service Contractor. The amount due shall be determined from the Payment Schedule in Appendix B.

Charges for hourly services will be determined in accordance with the Service Contractor's established time allocation procedures, and those of other organizations from whom hourly services are purchased.

Printed material, not listed in Appendix A, will be billed for specific items furnished.

The Service Contractor shall have the right to adjust their fees as of the date (a) the Plan is amended to modify

benefits, or (b) its cost of operation is increased solely by virtue of a change in charges to the Service Contractor by a governmental unit, but such adjustment shall be limited to the amount of the change. The Service Contractor also shall have the right to adjust their fees on the annual anniversary of this Agreement and annually thereafter.

Section 5. General Provisions

(a) The Service Contractor in performing its duties under this Agreement is acting only as agent of the Client, and the rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise herein provided.

(b) The Service Contractor shall use reasonable care and diligence in the exercise of its powers and the performance of its duties hereunder, but shall not be liable for any mistake of judgment or other action taken in good faith, or for any loss unless resulting from its gross negligence.

(c) The Service Contractor agrees to indemnify the Client and hold the Client harmless against any and all loss, damage, and expense, including court costs and attorney's fees, resulting from or arising out of the dishonest, fraudulent, criminal acts or acts of gross negligence of the Service Contractor's employees, either acting alone or in collusion with others. The Service Contractor shall maintain Blanket Bond Coverage with a limit in reasonable proportion in the volume of claims administered.

(d) Except as provided in (c) above, the Client agrees to indemnify the Service Contractor and hold the Service Contractor harmless against any and all loss, damage, and expense, including court costs and attorney's fees, resulting from or arising out of claims, demands, or lawsuits brought against the Service Contractor in administering the Plan or to recover benefits under the Plan. Including compensatory, puni-

tive, or other damages, and including but not limited to claims for premium taxes by any governmental unit or other assessments made against the Service Contractor by governmental units.

(e) The duties to be performed by the Service Contractor under this Agreement may, at its discretion, be performed directly, wholly or in part, under a contract with an organization of its choosing.

(f) The Service Contractor shall consult with the Client or legal counsel designated by the Client in claim matters that are beyond the ordinary. In the defense of any legal action on a claim for benefits, the Service Contractor will furnish the Client and his legal counsel all pertinent information regarding the disputed claim, including the basis for its denial. The defense of any legal action on a claim for benefits shall not be the obligation of the Service Contractor.

(g) The Service Contractor shall be entitled to rely upon any communication believed by the Service Contractor to be genuine and to have been signed or presented by the proper party or parties.

The Service Contractor shall not be bound by any notice, direction, requisition, or request unless and until it shall have been received in writing, or telegraph, by the Service Contractor at its St. Louis, Missouri address, or at such other address as the Service Contractor specifies for the purposes of this Agreement by notice in writing addresed to the Client. Notices or communications from the Service Contractor to the Client shall be addressed to the Client and shall be sent by mail or telegraph to the Client at the same address designated by the Client, except as otherwise provided in Section II.

(h) The Service Contractor shall have no power or authority to alter, modify, or waive any terms or con-

ditions ofthe Plan, or to waive any breach of any such terms or conditions, or to bind the Client, or to waive any of its rights, by making any statement or by receiving at any time any notice or information.

(i) The Service Contractor shall have no power or authority to act for or on behalf of the Client other than as herein expressly granted, and no other or greater power or authority shall be implied by the grant or denial of power or authority specifically mentioned herein.

(j) The Service Contractor shall hold as the property of the Client all papers, books, files, correspondence and records of all kinds which at any time shall come into its possession or under its control relating to the transactions performed by the Service Contractor for the Client under this Agreement, and shall surrender them to the Client upon termination of this Agreement or upon prior request, except the Service Contractor may periodically destroy such material as it would usually destroy in the normal course of business.

(k) The Client shall have the right at all reasonable times to inspect at the claim office of the Service Contractor all books and documents relating to the administration of the Plan under this Agreement and which relate to such inspection. Any costs of such inspection shall be borne by the Client.

(l) Failure by the Client or the Service Contractor to insist upon compliance with any provision of this Agreement at any given time or under any given set of circumstances shall not operate to waive or modify such provision or in any manner render it unenforceable, as to any other time or as to any other occurrence, whether the circumstances, are, or are not, the same and no waiver of any of the terms or conditions

of this Agremeent shall be valid or of any force or effect unless contained in a written instrument specifically expressing such waiver and signed by a person duly authorized to sign such waiver.

No alteration or modification of the terms and conditions of this Agreement shall be valid or of any force or effect unless in each instance it is contained in a written instrument expressing such alteration or modification and executed for the Client and the Service Contractor by their officers duly authorized to execute such alteration or modification.

(m) This Agreement, including any appendices or supplements thereto, shall constitute the entire contract between the parties and shall govern the rights, liabilities and obligations of the parties hereto, except as it may be modified in accordance with the provisions of Section 5(1).

(n) Any assignment of this Agreement or of any rights hereunder shall be void and of no force or effect.

(o) It is understood that the Service Contractor performs purely ministerial functions for the Client within a framework of policies, interpretations, rules, practices and procedures made by the Client.

(p) Under no circumstances shall the Service Contractor be considered the named fiduciary under the Plan.

Section 6. Controlling Law

This Agreement shall be construed and enforced according to the laws of California.

Section 7. Separability

In the event any provision of this Agreement shall be held illegal or invalid for any reason by law or a court of competent jurisdiction, said illegality or invalidity shall not affect the remaining parts of this Agreement, but it shall

be construed and enforced as if said illegal or invalid provisions had not been included herein either initially, or beyond the date it is first held to be illegal or invalid if after the effective date of this Agreement, provided the basic purposes hereof can be effectuated through the remaining valid and legal provisions.

Section 8. Gender and Number

Any reference in the masculine gender herein shall be deemed to also include the feminine gender, unless expressly provided otherwise. Wherever appropriate, any reference in this instrument in the singular shall include the plural, and any references in the plural shall include the singular.

Section 9. Counterparts

This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, and said counterparts shall constitute but one and the same instrument.

Section 10. Currency and Place of Payments

All sums payable to, or payable by, the Service Contractor pursuant to this Agreement shall be payable in the lawful currency of the United States of America at its St. Louis, Missouri office.

Section 11. Termination of Agreement

(a) If any state or other jurisdiction enacts a law which prohibits the continuance of this Agreement, or the existing law is interpreted to so prohibit the continuance of this Agreement, the Agreement shall terminate automatically as to such time or jurisdiction on the effective date of such law or interpretation.

(b) The Client reserves the right to terminate this Agreement as of any anniversary of the effective date of this

Agreement by giving written notice to the Service Contractor at least thirty-one (31) days in advance of such date.

(c) The Service Contractor reserves the right to terminate this Agreement

(i) as of January 1, 1989, or any anniversary of that date, by giving written notice to the Client at least sixty (60) days in advance of such date, and

(ii) if the Client fails to make payments pursuant to Section 4, or to deposit funds in the Benefit Plan Account to cover checks issued by the Service Contractor. Termination of this Agreement in accordance with this item (ii) will be effective immediately upon written notice from the Service Contractor to the Client. Such notice may be by telegram, teletype, or delivered in person.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to executed by their respective officers duly authorized to do so, to effective as of December 1, 1987.

Dated at _____ this ____ day of _____.

IT CORPORATION

By /s/ [Illegible]

[Illegible]

(Official Title)

GENERAL AMERICAN LIFE INSURANCE COMPANY

By /s/ [Illegible]

[Illegible]

(Official Title)

STATUTORY PROVISIONS

ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A):

Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

ERISA § 402(a)(1), (b)(2), 29 U.S.C. § 1102(a)(1), (b)(2):

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(b) Requisite features of plan

Every employee benefit plan shall—

* * * *

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

ERISA § 405(c)(1), 29 U.S.C. § 1105(c)(1):

(c) Allocation of fiduciary responsibility; designated persons to carry out fiduciary responsibilities

(1) The instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries, and (b) for named fiduciaries to designate persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the plan.

ERISA § 412(a), 29 U.S.C. § 1112(a):

Bonding

(a) Requisite bonding of plan officials

Every fiduciary of an employee benefit plan and every person who handles funds or other property of such a plan (hereafter in this section referred to as "plan official") shall be bonded as provided in this section; except that—

(1) where such plan is one under which the only assets from which benefits are paid are the general assets of a union or of an employer, the administrator, officers, and employees of such plan shall be exempt from the bonding requirements of this section, and

(2) no bond shall be required of a fiduciary (or of any director, officer, or employee of such fiduciary) if such fiduciary—

(A) is a corporation organized and doing business under the laws of the United States or of any State;

(B) is authorized under such laws to exercise trust powers or to conduct an insurance business;

(C) is subject to supervision or examination by Federal or State authority; and

(D) has at all times a combined capital and surplus in excess of such a minimum amount as may be established by regulations issued by the Secretary, which amount shall be at least $1,000,000. Paragraph (2) shall apply to a bank or other financial institution which is authorized to exercise trust powers and the deposits of which are not insured by the Federal Deposit Insurance Corporation, only if such bank or institution meets bonding or similar requirements under State law which the Secretary determines are at least equivalent to those imposed on banks by Federal law.

The amount of such bond shall be fixed at the beginning of each fiscal year of the plan. Such amount shall be not less than 10 per centum of the amount of funds handled. In no case shall such bond be less than $1,000 nor more than $500,000, except that the Secretary, after due notice and opportunity for hearing to all interested parties, and after consideration of the record, may prescribe an amount in excess of $500,000, subject to the 10 per centum limitation of the preceding sentence. For purposes of fixing the amount of such bond, the amount of funds handled shall be determined by the funds handled by the person, groups, or class to be covered by such bond and by their predecessor or predecesors, if any, during the preceding reporting year, or if the plan has no preceding reporting year, the amount of funds to be handled during the current reporting year by such person, group, or class, estimated as provided in regulations of the Secretary. Such bond shall provide protection to the plan against loss by reason of acts of fraud or dishonesty on the part of the plan official, directly or through connivance with others. Any bond shall have as surety thereon a corporate surety company which is an acceptable surety on Federal bonds under authority granted by the Secretary of the Treasury pursuant to sections 9304-9308 of Title 31. Any bond shall be in a form or of a type approved by the Secretary, including individual bonds or schedule or blanket forms of bonds which cover a group or class.

ERISA § 503, 29 U.S.C. § 1133:

Claims procedure

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

REGULATIONS

29 C.F.R. § 2509.75-8(D-2, -3):

D-2 Q: Are persons who have no power to make any decisions as to plan policy, interpretations, practices or procedures, but who perform the following administrative functions for an employee benefit plan, within a framework of policies, interpretations, rules, practices and procedures made by other persons, fiduciaries with respect to the plan;

(1) Application of rules determining eligibility for participation or benefits;

(2) Calculation of services and compensation credits for benefits;

(3) Preparation of employee communications material;

(4) Maintenance of participants' service and employment records;

(5) Preparation of reports required by government agencies;

(6) Calculation of benefits;

(7) Orientation of new participants and advising participants of their rights and options under the plan;

(8) Collection of contributions and application of contributions as provided in the plan;

(9) Preparation of reports concerning participants' benefits.

(10) Processing of claims; and

(11) Making recommendations to others for decisions with respect to plan administration?

A: No. Only persons who perform one or more of the functions described in section 3(21)(A) of the Act with

respect to an employee benefit plan are fiduciaries. Therefore, a person who performs purely ministerial functions such as the types described above for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority or discretionary control respecting management of the plan, does not exercise any authority or control respecting management or idsposition of the assets of the plan, and does not render investment advice with respect to any money or other property of the plan and has no authority or responsibility to do so.

However, although such a person may not be a plan fiduciary, he may be subject to the bonding requirements contained in section 412 of the Act if he handles funds or other property of the plan within the meaning of applicable regulations.

The Internal Revenue Service notes that such persons would not be considered plan fiduciaries within the meaning of section 4975(e)(3) of the Internal Revenue Code of 1954.

D-3 Q: Does a person automatically become a fiduciary with respect to a plan by reason of holding certain positions in the administration of such plan?

A: Some offices or positions of an employee benefit plan by their very nature require persons who hold them to perform one or more of the functions described in section 3(21)(A) of the Act. For example, a plan administrator or a trustee of a plan must, be the very nature of his position, have "discretionary authority or discretionary responsibility in the administration" of the plan within the meaning of section 3(21)(A)(iii) of the Act. Persons who hold such positions will therefore be fiduciaries.

Other offices and positions should be examined to determine whether they involve the performance of any of

the functions described in section 3(21)(A) of the Act. For example, a plan might designate as a "benefit supervisor" a plan employee whose sole function is to calculate the amount of benefits to which each plan participant is entitled in accordance with a mathematical formula contained in the written instrument pursuant to which the plan is maintained. The benefit supervisor, after calculating the benefits, would then inform the plan administrator of the results of his calculations, and the plan administrator would authorize the payment of benefits to a particular plan participant. The benefit supervisor does not perform any of the functions described in section 3(21)(A) of the Act and is not, therefore, a plan fiduciary. However, the plan might designate as a "benefit supervisor" a plan employee who has the final authority to authorize or disallow benefit payments in cases where a dispute exists as to the interpretation of plan provisions relating to eligibility for benefits. Under these circumstances, the benefit supervisor would be a fiduciary within the meaning of section 3(21)(A) of the Act.

The Internal Revenue Service notes that it would reach the same answer to this question under section 4975(e)(3) of the Internal Revenue Code of 1954.

29 C.F.R. § 2560.503-1:

Claims procedure.

(a) *Scope and purpose.* (1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggregate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3.

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or procesing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraphs (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) A grievance and arbitration procedure to which denied claims are subject.

(ii) Such plan will be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.* (1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(4) For purposes of paragraphs (d)(1), (2), and (3) of this section, a communication shall be deemed to have been brought to the attention of an organizational unit if it is received by any person employed in such unit.

(e) *Notification to claimant of decision.* (1) If a claim is wholly or partially denied, notice of the decision, meeting the requirements of paragraph (f) of this section, shall be furnished to the claimant within a reasonable period of time after reecipt of the claim by the plan.

(2) If notice of the denial of a claim is not furnished in accordance with paragraph (e)(1) of this section within a reasonable period of time, the claim shall be deemed denied and the claimant shall be permitted to proceed to the review stage described in paragraph (g) of this section.

(3) for purposes of paragraph (e)(1) and (2), of this section, a period of time will be deemed to be unreasonable if it exceeds 90 days after receipt of the claim by the plan, unless special circumstances requires an exten-

sion of time for processing the claim. If such an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the final decision.

(f) *Content of notice.* A plan administrator or, if paragraph (c) of this section is applicable, the insurance company, insurance service, or other similar organization, shall provide to every claimant who is denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the denial;

(2) Specific reference to pertinent plan provisions on which the denial is based;

(3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

(3) A plan may establish a limited period within which a claimant must file any request for review of a denied claim. Such time limits must be reasonable and related to the nature of the benefit which is the subject of the claim and to other attendant circumstances. In no event may such a period expire less than 60 days after receipt by the claimant of written notification of denial of a claim.

(h) *Decision on review.* (1)(i) A decision by an appropriate named fiduciary shall be made promptly, and shall not ordinarily be made later than 60 days after the plan's receipt of a request for review, unless special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require an extension of time for processing, in which case a decision shall

be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

(ii) In the case of a plan with a committee or board of trustees designated as the appropriate named fiduciary, which holds regularly scheduled meetings at least quarterly, a decision on review shall be made by no later than the date of the meeting of the committee or board which immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a decision may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold a hearing, if the plan procedure provides for a hearing) require a further extension of time for processing, a decision shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review.

(2) If such an extension of time for review is required because of special circumstances, written notice of the extension shall be furnished to the claimant prior to the commencement of the extension.

(3) The decision on review shall be in writing and shall include specific reasons for the decision, written in a manner calculated to be understood by the claimant, as well as specific references to the pertinent plan provisions on which the decision is based.

(4) The decision on review shall be furnished to the claimant within the appropriate time described in paragraph (h)(1) of this section. If the decision on review is not furnished within such time, the claim shall be deemed denied on review.

(i) *Apprenticeship plans.* This section does not apply to employee benefit plans which provide solely apprenticeship training benefits.

(j) *Qualified Health Maintenance Organizations.* Claims procedures with respect to any benefits provided through membership in a qualified health maintenance organization, as defined in section 1310(d) of the Public Health Service Act, as amended, 42 U.S.C. 300e-9(d), shall be deemed to satisfy the requirements of this section with respect to the provision of such benefits to persons who are members of such qualified health maintenance organization, provided those procedures meet the requirements of section 1301 of the Public Health Service Act, as amended 42 U.S.C. 300e and the regulations thereunder.

29 C.F.R. § 2580.412-4, -6:

"Funds or other property" of a plan.

The affirmative requirement for bonding persons falling within the definition of administrator, officer or employee is applicable only if they handle "funds or other property" of the plan concerned. The term "funds or other property" is intended to encompass all property which is used or may be used as a source for the payment of benefits to plan participants. It does not include permanent assets used in the operation of the plan such as land and buildings, furniture and fixtures or office and delivery equipment used in the operation of the plan. It does include all items in the nature of quick assets, such as cash, checks and other negotiable instruments, government obligations and marketable securities. It also includes all other property or items convertible into cash or having a cash value and held or acquired for the ultimate purpose of distribution to plan participants or beneficiaries. In the case of a plan which has investments, this would include all the investments of the plan even though not in the nature of quick assets, such as land and buildings, mortgages, and securities in closely held corporations. However, in a given case, the question of whether a person was "handling" such "funds or other property" so as to require bonding would depend on whether his relation-

ship to this property was such that there was a risk that he, alone or in connivance with others, could cause a loss of such "funds or other property" through fraud or dishonesty.

Determining when "funds or other property" are "handled" so as to require bonding.

(a) *General scope of term.* (1) A plan administrator, officer, or employee shall be deemed to be "handling" funds or other property of a plan, so as to require bonding under section 13, whenever his duties or activities with respect to given funds or other property are such that there is a risk that such funds or other property could be lost in the event of fraud or dishonesty on the part of such person, acting either alone or in collusion with others. While ordinarily, those plan administrators, officers and employees who "handle" within the meaning of section 13 will be those persons with duties related to the receipt, safekeeping and disbursement of funds, the scope of the term "handles" and the prohibitions of paragraph (b) of section 13 shall be deemed to encompass any relationship of an administrator, officer or employee with respect to funds or other property which can give rise to a risk of loss through fraud or dishonesty. This shall include relationships such as those which involve access to funds or other property or decisionmaking powers with respect to funds or property which can give rise to such risk of loss.

(2) Section 13 contains no exemptions based on the amount or value of funds or other property "handled", nor is the determination of the existence of risk of loss based on the amount involved. However, regardless of the amount involved, a given duty or relationship to funds or other property shall not be considered "handling", and bonding is not required, where it occurs under conditions and circumstances in which the risk that a loss will occur through fraud or dishonesty is negligible. This may be the case where the risk of mishandling is precluded by the nature of the funds or other property (e.g., checks, securi-

ties or title papers which can not be negotiated by the persons performing duties with respect to them). It may also be the case where significant risk of mishandling in the performance of duties of an essentially clerical character is precluded by fiscal controls.

(b) *General criteria for determining "handling".* Subject to the application of the basic standard of risk of loss to each situation, general criteria for determining whether there is "handling" so as to require bonding are:

(1) *Physical contact.* Physical contact with cash, checks or similar property generally constitutes "handling". However, persons who from time to time perform counting, packaging, tabulating, messenger or similar duties of an essentially clerical character involving physical contact with funds or other property would not be "handling" when they perform these duties under conditions and circumstances where risk of loss is negligible because of factors such as close supervision and control or the nature of the property.

(2) *Power to exercise physical contact or control.* Whether or not physical contact actually takes place, the power to secure physical possession of cash, checks or similar property through factors such as access to a safe deposit box or similar depository, access to cash or negotiable assets, powers of custody or safekeeping, power to withdraw funds from a bank or other account generally constitutes "handling", regardless of whether the person in question has specific duties in these matters and regardless of whether the power or access is authorized.

(3) *Power to transfer to oneself or a third party or to negotiate for value.* With respect to property such as mortgages, title to land and buildings, or securities, while physical contact or the possibility of physical contact may not, of itself, give rise to risk of loss so as to constitute "handling", a person shall be regarded as "handling" such items where he, through actual or apparent authority, can cause those items to be transferred to himself or to a third party or to be negotiated for value.